NEBRASKA ELEMENTAL
FORMULA REIMBURSEMENT
PROGRAM

Department of Health & Human Services
DHHS
NEBRASKA

Application Form

Name of applicant (person who uses the formula) _____

Birth date of applicant _____

Applicant's Social Security Number _____

Name of parent/guardian if applicant is a minor _____

Parent/guardian's Social Security number if applicant is a minor _____

Address: _____

City/State/Zip+4:_____

Phone number: _____

E-mail address: _____

This form has multiple pages. Be sure to complete each page.

- Read the following conditions and sign and date, showing you understand and agree with these conditions:
  - I have read the program eligibility description or it has been read to me, at http://dhhs.ne.gov/publichealth/Pages/ElementalFormulaReimbursementProgram.aspx
  - Reimbursement is for out-of-pocket costs, not covered by private insurance, Medicaid, Medicare or other government insurance program, WIC, or charitable grants.
  - Fifty percent of these out-of-pocket costs will be reimbursed up to a total not to exceed $12,000 in a 12 month period.
  - Reimbursements will be made on a first-come, first-served basis until all available funds are expended each fiscal year.

- **You must place a check in ALL the boxes that are applicable to you –**

  ☐ I or my minor child has no private health insurance.

  OR

  ☐ I or my minor child has private health insurance that has denied coverage of the formula and **I have attached a copy of the insurance company's denial**.

  ☐ I or my minor child is not enrolled in WIC.

  OR

  ☐ I or my minor child is enrolled in WIC but I have purchased additional formula in excess of that provided by WIC.

  ☐ I or my minor child is not enrolled in Medicaid, Medicare, or other government insurance program such as Tricare.

  ☐ I have not received reimbursement from a charitable grant.

- Reimbursements will be made only when all required information is provided and applicants' eligibility is determined.

- All statements on this Application Form are true and complete;

Signature of applicant or parent/guardian if applicant is a minor:

_____ Date: _____

REMINDER

The submitted application will be reviewed and will be approved or denied. You will be notified through email of the determination. If approved, you will need to complete the Reimbursement Claim Form and attach your paid receipts.

Please remit no more than every thirty (30) days to allow for reimbursement payments to process.

Annual Physician's Statement

As the physician for _____, _____
(Patient Name) (Date of Birth)

I certify that this patient has a medical necessity for amino acid-based elemental formula for the diagnosis and treatment of:

☐ Immunoglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins

☐ Food-protein-induced enterocolitis syndrome

☐ Eosinophilic disorders

☐ Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

As such, I have ordered the following formula:

☐ Elecare

☐ Elecare Junior

☐ Pur Amino

☐ Neocate Infant

☐ EO28 Splash 8 oz. drink box

☐ Neocate, Junior 14.1 oz.

☐ Vivonex Pediatric 1.7 oz. packet

☐ Vivonex T.E.N. 2.84 oz. packet

PHYSICIAN'S SIGNATURE: _____

PRINTED NAME: _____

DATE: _____

IF PATIENT IS A MINOR, NAME(S) OF PARENT OR LEGAL GUARDIANS:

_____

Nebraska Elemental Formula Reimbursement Program - Lifespan Health Services Unit
dhhs.elementalformula@nebraska.gov – 1-800-801-1122

United States Citizenship Attestation

For the purpose of complying with Neb. Rev. Stat. §§ 4-108 through 4-114, I attest as follows:

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my or my minor child's lawful presence in the United States.

☐ I am or my minor child is a citizen of the United States.

- OR -

☐ I am or my minor child is a qualified alien under the federal Immigration and Nationality Act, my immigration status and alien number are as follows: _____ and I will provide a copy of my/his/her USCIS documentation.

PRINT NAME OF APPLICANT, OR PARENT/GUARDIAN IFAPPLICANT IS A MINOR CHILD _____
(first, middle, last)

SIGNATURE OF APPLICANT, OR PARENT/GUARDIAN IFAPPLICANT IS A MINOR CHILD _____

DATE _____

FOR OFFICE USE ONLY:

All documentation Provided _____ Yes _____ No If no, Applicant was contacted on _____ by _____

Application Approved: _____ by _____.

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